UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2021 P 1196-8
Program	Prior Authorization/Notification
Medication	Cabometyx® (cabozantinib)
P&T Approval Date	6/2016, 6/2017, 2/2018, 6/2018, 3/2019, 3/2020, 3/2021, 11/2021
Effective Date	2/1/2022; Oxford only: 2/1/2022

1. Background:

Cabometyx® (cabozantinib) is a kinase inhibitor indicated for the treatment of patients with advanced renal cell carcinoma (RCC), patients with advanced RCC as a first-line treatment in combination with Opdivo (nivolumab), patients with hepatocellular carcinoma (HCC) who have been previously treated with Nexavar® (sorafenib tosylate), and in adult and pediatric patients 12 years of age and older with locally advanced or metastatic differentiated thyroid cancer (DTC) that has progressed following prior VEGFR-targeted therapy and who are radioactive iodine-refractory or ineligible[1] In addition, the National Cancer Comprehensive Network (NCCN) recommends Cabometyx for the treatment of non-small cell lung cancer (NSCLC) with RET gene rearrangement and HCC as a single agent for progressive disease in patients who have unresectable disease and are not a transplant candidate, are inoperable by performance status or comorbidity, have local disease, metastatic disease or extensive liver tumor burden, osteosarcoma, Ewing sarcoma, gastrointestinal stromal tumors (GIST), kidney cancer, and endometrial carcinoma.[2]

Coverage Information:
Members will be required to meet the criteria below for coverage. For members under the age of 19 years, the prescription will automatically process without a coverage review.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

2. Coverage Criteria:

A. <u>Patients less than 19 years of age</u>

1. **Cabometyx** will be approved based on the following criterion**:**

   a. Patient is less than 19 years of age

Authorization will be issued for 12 months.

B. Renal Cell Carcinoma (RCC)

1. **Initial Authorization**

   a. **Cabometyx** will be approved based on of the following criterion:

      (1) Diagnosis of advanced renal cell carcinoma

   Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Cabometyx** will be approved based on the following criterion:

      (1) Patient does not show evidence of progressive disease while on Cabometyx therapy

   Authorization will be issued for 12 months.

C. Non-Small Cell Lung Cancer (NSCLC) =

1. Initial Authorization

   a. **Cabometyx** will be approved based on **both** of the following criteria:

      (1) Diagnosis of non-small cell lung cancer (NSCLC)

      -AND-

      (2) Positive for RET gene rearrangements

   Authorization will be issued for 12 months.

2. Reauthorization

   a. **Cabometyx** will be approved based on the following criterion:

      (1) Patient does not show evidence of progressive disease while on Cabometyx therapy

   Authorization will be issued for 12 months.

D. Hepatocellular Carcinoma

1. **Initial Authorization**

   a. **Cabometyx** will be approved based on **both** of the following criteria:

      (1) Diagnosis of hepatocellular carcinoma

      -AND-

      (2) **One** of the following:

         (a) History of contraindication, failure, or intolerance to Nexavar (sorafenib tosylate)

         -OR-

         (b) Patient has metastatic disease

         -OR-

         (c) Patient has extensive liver tumor burden

         -OR-

         (d) Patient is inoperable by performance status or comorbidity, or has local disease or local disease with minimal extrahepatic disease only

         -OR-

         (e) **Both** of the following:
            i. Patient is not a transplant candidate
            ii. Disease is unresectable

   Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Cabometyx** will be approved based on the following criterion:

      (1) Patient does not show evidence of progressive disease while on Cabometyx therapy

   Authorization will be issued for 12 months.

E. Osteosarcoma

1. **Initial Authorization**

   a. **Cabometyx** will be approved based on **all** of the following criteria:

      (1) Diagnosis of osteosarcoma

      -AND-

      (2) Patient's disease has progressed on prior treatment

      -AND-

      (3) **One** of the following:

         (a) Patient has relapsed/refractory disease

         -OR-

         (b) Patient has metastatic disease

      Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Cabometyx** will be approved based on the following criterion:

      (1) Patient does not show evidence of progressive disease while on Cabometyx therapy

      Authorization will be issued for 12 months.

F. Ewing Sarcoma

1. **Initial Authorization**

   a. **Cabometyx** will be approved based on **both** of the following criteria:

      (1) Diagnosis of Ewing sarcoma (including mesenchymal chondrosarcoma)

      -AND-

      (2) Patient has relapsed, progressive, or metastatic disease

      Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Cabometyx** will be approved based on the following criterion:

      (1) Patient does not show evidence of progressive disease while on Cabometyx therapy

      Authorization will be issued for 12 months.

G. Gastrointestinal Stromal Tumors

1. **Initial Authorization**

   a. **Cabometyx** will be approved based on **both** the following criteria:

      (1) Diagnosis of GIST

      -AND-

      (2) Patient has unresectable, recurrent, or metastatic disease after failure on approved therapies (e.g., imatinib)

      Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Cabometyx** will be approved based on the following criterion:

      (1) Patient does not show evidence of progressive disease while on Cabometyx therapy

      Authorization will be issued for 12 months.

H. Kidney Cancer

1. **Initial Authorization**

   a. **Cabometyx** will be approved based on **both** of the following:

      (1) Diagnosis of kidney cancer

      -AND-

      (2) **One** of the following:

         (a) Patient has relapsed disease

-OR-

(b) Patient has metastatic disease

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Cabometyx** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Cabometyx therapy

Authorization will be issued for 12 months.

I. Endometrial Carcinoma

1. **Initial Authorization**

a. **Cabometyx** will be approved based on **all** of the following:

(1) Diagnosis of endometrial carcinoma

-AND-

(2) Disease is recurrent, high-risk, or metastatic

-AND-

(3) Used as second-line treatment

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Cabometyx** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Cabometyx therapy

Authorization will be issued for 12 months.

J. Thyroid Cancer

1. **Initial Authorization**

a. Cabometyx will be approved based on **all** of the following:

(1) Diagnosis of differentiated thyroid cancer (DTC)

-AND-

(2) Disease is locally advanced or metastatic

-AND-

(3) Disease has progressed following prior VEGFR-targeted therapy

-AND-

(4) Disease is radioactive iodine-refractory or ineligible

Authorization will be issued for 12 months.

2. Reauthorization

a. Cabometyx will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Cabometyx therapy

Authorization will be issued for 12 months.

K. NCCN Recommended Regimens

The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Cabometyx [prescribing information]. South San Francisco, CA: Exelixis, Inc.; September 26, 2021.

2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed September 26, 2021.

Program	Prior Authorization/Notification – Cabometyx (cabozantinib)
Change Control	
6/2016	New program.
6/2017	Annual review with no changes to clinical criteria.
2/2018	Updated background and criteria to include new indication for first line therapy for RCC. Added coverage for NCCN recommended use for NSCLC.
6/2018	Annual review with no changes to clinical criteria.
3/2019	Updated background and criteria to include new indication for second line therapy for HCC and NCCN recommended use for HCC.
3/2020	Annual review. Updated RCC criteria to only require a diagnosis of advanced renal cell carcinoma to align with label. Added standard language for NCCN recommended regimens.
3/2021	Annual review. Updated background and criteria to include new NCCN recommendations for osteosarcoma, Ewing sarcoma, GIST and kidney cancer.
11/2021	Updated background and criteria to include Endometrial carcinoma and new indication for thyroid cancer. Updated references.